THE STATE of ALASKA
*Department of Commerce, Community, and Economic Development*
*Division of Corporations, Business and Professional Licensing*

**Alaska State Medical Board**
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: MedicalBoard@Alaska.Gov
Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

# Application for Courtesy License

**Purpose of a Courtesy License**
Alaska law provides for the issuance of a courtesy license to a physician for specific, limited purposes. The courtesy license is valid only for the duration of the activity but may not exceed one year in length.

1. Physicians who will be working in a supervised hospital fellowship;
2. Physicians who will be working in a specialty clinic where there is no fee or other remuneration paid by the patients for the service;
3. Physicians who will be working in specialty clinics under formal contract to a state office;
4. Sports team physicians who are accompanying their teams to this state for competition;
5. Physicians who will be accompanying their employer/patient to the state;
6. Physicians who will be providing emergency medical care or emergency mental health care, as part of an organized response to a state declared disaster that resulted in injuries or death.

**QUALIFICATIONS FOR COURTESY LICENSE**

- Successful graduation from an accredited medical school if U.S. or Canadian graduate; if other international medical school graduate, successful graduation from a school listed in the World Directory of Medical schools.
- Successful completion of postgraduate training.
- Active license in good standing (no disciplinary sanctions or restrictions) in state of residence; cannot be under investigation.
- Board certification in at least one of the 24 member boards of the American Board of Medical Specialties.

**The following documents must be on file with our office before the Board will consider your application for Courtesy License:**

**1. APPLICATION**
A completed signed application (pages 1-9).

**2. FEES**
Fees made payable to "State of Alaska" in accordance with 12 AAC 02.250.

| | |
|---|---|
| Nonrefundable Application Fee: | $100.00 |
| Courtesy License Fee: | $150.00 |
| Prescription Drug Monitoring Program (PDMP) Fee (if applicable): | $ 25.00 |

**3. AUTHORIZATION FOR RELEASE OF RECORDS**
A completed Authorization for Release of Records form (#08-4288a).

**4. STATEMENT OF PURPOSE**
A completed Statement of Purpose form (#08-4288b).

**5. VERIFICATION OF LICENSURE**
Verification of Licensure form (#08-4288c) from all licensing jurisdictions where you have ever been licensed as any health care professional (e.g., physician assistant, nurse, MICP, dentist, optometrist, etc.).

**6. CURRICULUM VITAE**
A copy of your current curriculum vitae.

**7. CLEARANCE REPORT – DEA**
A completed Clearance Report form (#08-4288e) from the Drug Enforcement Administration.

**8. CLEARANCE REPORT – FSMB**
A completed Clearance Report form (#08-4288f) from the Federation of State Medical Boards.

**9. MEDICAL SCHOOL DIPLOMA**
A certified true copy of your medical school diploma.

**10. POST GRADUATE TRAINING PROGRAM CERTIFICATES**
Certified true copies of the postgraduate training program certificates.

**11. BOARD CERTIFICATE** *(if applicable)*
A certified true copy of the Board Certificate (must be for an ABMS member board).

**12. FELLOWSHIP SCOPE OF PRACTICE STATEMENT** *(if applicable)*
A completed Fellowship Scope of Practice Statement (#08-4288d) if courtesy license is for a fellowship position - not required otherwise.

All applications must be accompanied by the appropriate fees. Personal checks, cashier's checks, or money orders must be made payable to the State of Alaska. Incorrect fees will delay processing of your application.

**APPLICATION STATUS UPDATES**
Our licensing examiner will send you a written status update upon the initial screening of the application.

**COMPLETION OF THE APPLICATION FORMS**
Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

**Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if you are issued a license or permit by the board. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.**

**CERTIFIED TRUE COPIES**
To obtain a certified true copy, take the original document to a notary public so he/she may compare the original to the photocopy of the document. **The notary must write "I certify this to be a true copy of the original document" on the photocopy and attest to the fact by signing and notarizing the document.**

**CONFIDENTIALITY**
The contents of licensing files are generally considered public. If you believe the additional information you are attaching to explain a "yes" answer should be held confidential, so state in the attachment. A request for confidentiality may or may not be granted.

**FAX DOCUMENTS**
Fax copies of documents are **NOT** accepted for documentation or verification in our licensing process.

**FOREIGN LANGUAGE DOCUMENTS**
All foreign language documents must be certified true copies and must be accompanied by a certified translation into English by a recognized translator.

**LICENSE APPLICATION PROCESSING STAFF**
Please visit our website to find the contact information for your Licensing Examiner:
*ProfessionalLicense.Alaska.Gov/StateMedicalBoard* or call (907)465-2550.

**LICENSING PROCESS**
Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status. Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board's administrator who reviews the entire file. At the discretion of the administrator, a courtesy license may be issued.

Applications will be processed in the order in which they are received in the board's office. Please ensure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

**PAYMENT OF CHILD SUPPORT**
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

**PERSONAL INTERVIEWS**
Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

**PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)**
A licensee may not prescribe or dispense a controlled substance until registration with the PMDP is complete. All Alaska-licensed practitioners with a DEA registration must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing a federally scheduled II or III controlled substance. *PDMP.Alaska.Gov*

**PROCESSING TIME**
In general, average processing time for a courtesy license is six to eight weeks. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued.

If there are any "Yes" responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

**SOCIAL SECURITY REQUIREMENT**
Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

**STALE DOCUMENTS**
If during the license application process certain documents become older than twelve months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application document, verifications of licensure from other licensing jurisdictions, the DEA clearance report and the FSMB Board Action Data Bank report.

**TELEPHONE QUERIES**
We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only**. We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

**WEBSITE ADDRESS**
The Division of Corporations, Business and Professional Licensing maintains a website where you may check to see if your license or permit has been issued. The address is *ProfessionalLicense.Alaska.Gov*

The medical board's website is *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

**"YES" RESPONSES**
A "Yes" response in the application does not mean your application will be denied. If you have responded "Yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information. **You can expedite this process by providing with your application complete explanations and documentation for any "Yes" responses.**

## HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. Ensure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
4. Provide complete explanations for any "Yes" responses. It saves time if we don't have to contact you and request such information.
5. Provide a brief description for any malpractice claims describing the allegation, the nature of the case, your level of involvement, and the resolution of the case.

**WHEN IN DOUBT, DISCLOSE AND EXPLAIN.**

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**MED**

FOR DIVISION USE ONLY

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Website: *ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

# Courtesy License Application

## PART I Payment of Fees

| | | |
|---|---|---|
| **Required Fees:** | ☐ Nonrefundable Application Fee | **$100.00** |
| | ☐ Courtesy License Fee | **$150.00** |
| **PDMP Fees:** | ☐ I have an active DEA registration to use in any state or practice location. | **$ 25.00** |
| | ☐ I do not have the ability to prescribe or dispense controlled substances in any state or to Alaskan Residents. | **No Fee** |

## PART II Professional Designation

| | | |
|---|---|---|
| **Profession:** | ☐ Allopathic Physician (MD) | ☐ Osteopathic Physician (DO) |
| **Applying By:** | ☐ Examination *(not licensed in another state)* | ☐ Credentials *(licensed in another state)* |

## PART III Applicant Information

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | | |
| **Provide all other names used (maiden, nicknames, aliases). Attach documentation of all legal name changes.** ☐ Not Applicable ☐ Other Names Used: _____ | | | |
| **Residence Address:** | | | |
| **Practice Address:** | | | |
| **Which address do you want to use for your mailing address and for the public record:** | | ☐ Residence Address ☐ Practice Address | |
| **Birth Date:** (mm/dd/yyyy) | | **Birthplace:** | |
| **Phone:** | | **Gender:** | |
| **EMAIL AGREEMENT**: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure. | | | |
| **Email Address:** | | ☐ Send my Correspondence by Email ☐ Send my Correspondence by US Mail | |
| **SOCIAL SECURITY NUMBER**: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure. | | | |

## PART IV Alaska License or Permit

| Complete the following if you have previously held a license or permit in Alaska. | | | | |
|---|---|---|---|---|
| **Previous License or Permit Type:** | ☐ Permanent | ☐ Resident | ☐ Locum Tenens | ☐ Temporary |
| **Previous AK license or Permit Number:** | | **Date Issued:** | | |

## PART V Education

### Medical School Education

*List the medical school(s) you attended and from which you graduated. If you attended more than one medical school, provide your reason for changing medical schools on a separate sheet of paper signed and dated by you.*

| | | | |
|---|---|---|---|
| **Name of Institution:** | | | |
| **Location (City, State):** | | **Date Graduated:** | |
| **Name of Institution:** | | | |
| **Location (City, State):** | | **Date Graduated:** | |

### Postgraduate Training

**List Internship, Residency, or Fellowship Training Programs Chronologically.**

| Name of Institution | Address | Dates (From/To) | | Completed? (Yes/No) |
|---|---|---|---|---|
| 1st Yr. | | | | ☐ Yes ☐ No |
| 2nd Yr. | | | | ☐ Yes ☐ No |
| 3rdYr. | | | | ☐ Yes ☐ No |
| 4th Yr. | | | | ☐ Yes ☐ No |
| 5th Yr. | | | | ☐ Yes ☐ No |
| 6th Yr. | | | | ☐ Yes ☐ No |

### ECFMG Certification – International Graduates Only

| Have you taken the ECFMG Exam? | ☐ No ☐ Yes | Certification Number: | |
|---|---|---|---|
| ***If yes, you must attach a certified true copy of the certificate to this application.*** | | | |

## PART VI Examination History

**Please specify National Boards, FLEX, LMCC, USMLE or a state-administered medical licensing examination.**

| Exam Series | Location | Date Administered | Result |
|---|---|---|---|
| | | | ☐ Pass ☐ Fail |
| | | | ☐ Pass ☐ Fail |

## PART VII Specialty

**Board certification is required in at least one of the 24 member boards of the American Board of Medical Specialties.**

| ABMS Specialty Board: | Date of Certification/Recertification: |
|---|---|
| | |
| | |

## PART VIII Military Service

| | | | |
|---|---|---|---|
| **Have you ever been in the armed forces?** | ☐ No ☐ Yes | | |
| **Branch of Service:** | | **Date of Commission:** | |
| **Type of Discharge:** | | **Date of Discharge:** | |
| **Location(s) Where You Served:** | | | |

## PART IX Professional Licensure

**Professional Licensure:** Please list all states, territories, provinces, or foreign countries in which you are or have ever been licensed as any health care professional. Include instructional or training permits.

***If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.***

| Location | License Number | Issue Date | Current Status |
|---|---|---|---|
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## PART X Medical Societies and Professional Organizations

| Name of Organization | Address | Dates (From/To) | |
|---|---|---|---|
| | | | |
| | | | |

## PART XI Hospital Affiliations

**Please list all hospitals in which you are currently credentialed.**

| Hospital | Mailing Address | When Credentialed? |
|---|---|---|
| | | |
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## PART XII Opioid Education

☐ I have earned at least two hours of education in pain management, opioid use, and addiction; the course is AMA category 1, or AOA category 1 or 2, or CPME-approved. I will provide a Certificate of Completion that confirms at least two hours of credit covering all three areas of the required subject matter: pain management, opioid use, addiction.

☐ I request a waiver of the requirement for two hours of education in pain management, opioid use, and addiction until I apply for a DEA registration number.

## PART XIII DEA Registration and PDMP Acknowledgement

**1. Do you have a DEA Registration in any state?**

☐ **a. NO**, I do not have an active DEA registration valid to use in any state or practice location. I understand if I obtain a DEA registration, I must register with the Alaska PDMP within 30 days of obtaining a DEA registration as required by the board. I will refer to all applicable authorizing statutes, regulations cited above, and comply with mandatory use.

☐ **b. YES**, I have an active DEA registration valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this permit or license, as required by the board, and will comply with mandatory use as required by AS 17.30.200 and 12 AAC 40.967.

If I have a change in DEA registration number or status, I also understand I must promptly submit the DEA Registration Status Change Form (#08-4763).

***If you're unsure of the DEA issue date, indicate January 1st of the estimated year.***

| DEA Registration Number: | | Issue Date: | | Expiration Date: | |
|---|---|---|---|---|---|

**<u>If YES to #1 above, please answer the following</u>:**

**2. Do you plan to directly dispense a federally scheduled II - IV controlled substance beyond a 3-day supply AND in practice locations not exempt under AS 17.30.200(t)? Direct dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.**

*Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, and emergency departments.*

☐ **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **NO,** I do not plan to directly dispense and acknowledge that if, at any time after my permit or license is issued, I begin directly dispensing any federally-scheduled II – IV controlled substance for more than 3 days unless exempt by AS 17.30.200(t), I must submit a data request through PMP ClearingHouse or report directly to AWARxE for any controlled substance issued. If you are not directly dispensing, you must report to PMP ClearingHouse or directly to AWARxE. Please visit *PDMP.Alaska.Gov*

## PART XIV Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date with no more than a 60-day gap in time. You may attach a detailed curriculum vitae as long as all information is included. If necessary, make additional copies of this page, or continue to list your work history on a separate sheet labeled with your name and signed by you.

**Please explain any gap in time from practice of more than sixty (60) days' duration. If you have retired from practice, provide the dates.**

| Dates (from/to) | | Facility/Location | Activity |
|---|---|---|---|
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## PART XV Medical Malpractice History

| Have you ever had any claims of malpractice filed against you? | ☐ No | ☐ Yes |
|---|---|---|

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed below, provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name and signed by you; include a brief description regarding the nature of the case, the allegations, and your response to the allegations. *Letters from attorneys or insurance carriers **may not** be substituted for this required explanation.* Documentation includes a copy of the order for settlement, dismissal, or removal from the case, or other documentation to support your explanation. Please do not send all of the motions or filings for the case.

***If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.***

| Date of Case (mm/yyyy) | State/Jurisdiction | Nature of Allegation | Amount of Award or Settlement |
|---|---|---|---|
| | | | |
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## PART XVI Professional Fitness Questions – Disciplinary History

The following questions must be answered. "Yes" answers may not automatically result in license denial. You must answer both parts of each multi-part question**.**

**For each "Yes" response to any question, you must provide an explanation and documentation.** Provide your explanation on a separate sheet of paper labeled with your name and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. Documentation includes copies of court orders, charging documents, board, or license actions, etc. When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. You must include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

# When in doubt, disclose and explain.

| | | | |
|---|---|---|---|
| **1.** | Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **2.** | Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |

## PART XVI Professional Fitness Questions (Disciplinary History - Continued)

| | | | |
|---|---|---|---|
| **3.** | Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **4.** | Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **5.** | Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges, or investigated a complaint or accusation regarding your practice (except for late medical records)? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **6.** | Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction or termination? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **7.** | Have you ever been denied privileges or voluntarily or involuntarily resigned, restricted, or withdrawn your privileges from any hospital, clinic, health management organization or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **8.** | Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of "discipline" on page 6.) | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **9.** | Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (Please read definition of "discipline" on page 6.) | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **10.** | Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **11.** | Have you ever had a medical license application denied by any medical licensing jurisdiction or authority? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **12.** | Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **13.** | Have you voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |
| **14.** | Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine? | **Yes** ☐ | **No** ☐ |
| | Is any such action pending? | **Yes** ☐ | **No** ☐ |

## PART XVII Professional Fitness Questions – Personal History

The following questions must be answered. "Yes" answers may not automatically result in license denial.

**For each "Yes" response to any question, you must provide an explanation and documentation.** Provide your explanation on a separate sheet of paper labeled with your name and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. Documentation includes copies of court records, judgments, charging documents, etc. You must also have your treating physician submit a letter directly to the Board; the letter must include the following information:

- Summary of your diagnoses (including explanation, dates of onset and significant events, and frequency of contact with you)
- Medication history
- Impact on your ability to practice safely and competently

When in doubt about your response, disclose and provide the required explanation and documents. Applications submitted without the required attachments will be considered incomplete and will not be processed.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

**For the purposes of the questions in this section:**

"Medical Condition" includes physiological, mental, or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Controlled Substances" means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

| | | | |
|---|---|---|---|
| **15.** | In the past two years, have you been diagnosed as having, or been hospitalized for, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? | **Yes** ☐ | **No** ☐ |
| **16.** | Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? | **Yes** ☐ | **No** ☐ |
| **17.** | In the past two years, have you been the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner? | **Yes** ☐ | **No** ☐ |
| **18.** | Are you currently engaged in the illegal use of drugs, or the use of illegal drugs? | **Yes** ☐ | **No** ☐ |
| **19.** | In the past two years, have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner? | **Yes** ☐ | **No** ☐ |
| **20.** | Are you currently taking a controlled substance that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? | **Yes** ☐ | **No** ☐ |
| **21.** | Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? | **Yes** ☐ | **No** ☐ |

THE STATE of ALASKA

*Department of Commerce, Community, and Economic Development*
*Division of Corporations, Business and Professional Licensing*

FOR DIVISION USE ONLY

**Alaska State Medical Board**
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: *MedicalBoard@Alaska.Gov*
*ProfessionalLicense.Alaska.Gov/StateMedicalBoard*

# Notary Signature Page

## PART XVIII Notarized Signature

I certify that the information in this application is true and correct to the best of my knowledge. I understand that if information is provided in the Criminal History Report from the State of Alaska, or FBI, that I did not report, the issuance of my license may be delayed or denied. I further certify that all credentials and supporting documents supplied by me are true and correct and that the photograph below is a true likeness of me taken within the past 60 days.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

| Current Passport-Type Photo | | | | |
|---|---|---|---|---|
| | **Applicant's Printed Name:** | | | |
| | **Applicant's Signature:** | | | |
| | **Notary Public for State of:** | | **Subscribed and Sworn to Before me on this Day:** | |
| | **Notary's Signature:** | | **My Commission Expires:** | |

NOTARY SEAL

THE STATE of ALASKA
*Department of Commerce, Community, and Economic Development*
*Division of Corporations, Business and Professional Licensing*

State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: *License@Alaska.Gov*

# Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form **only** to explain and document any professional fitness "Yes" answers. A "Yes" answer is not necessarily disqualifying, but concealing one may be.

Each "Yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "Yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include but not be limited to; suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "Yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

| | |
|---|---|
| | **Write the professional fitness question number you are answering "Yes" to in the box.** |

| | | | |
|---|---|---|---|
| **Location of Incident:** | | **Date of Incident:** | |
| **Explanation of Incident:** | | | |
| **When in doubt, disclose and explain.**<br>**Make copies as necessary.** | | | |

**Did you attach all applicable documents associated with this incident?**

- ☐ Court orders
- ☐ Consent agreements
- ☐ Disciplinary actions
- ☐ Charging documents
- ☐ Court records
- ☐ Fitness to practice
- ☐ All other documentation related to this incident
- ☐ I have additional incidents for this "Yes" answer, or "Yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

| | | | |
|---|---|---|---|
| **Full Name:** | | **PL Code:** | |
| **Signature:** | | **Date:** | |

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# Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

| | | | |
|---|---|---|---|
| **Name:** | First Middle Last | | |
| **Full Address:** | Street or PO Box City State Zip | | |
| **Phone:** | | **Birth Date:** (mm/dd/yyyy) | |
| **Email:** | | | |
| **Signature:** | | **Date:** | |

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# Courtesy License Statement of Purpose

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | **MD/DO:** | |
| **Start Date:** | | **End Date:** | |

**Please check the appropriate purpose for which you intend to use the courtesy license in Alaska.**

☐ **1. Specialty Clinic where patients do not pay fees.**

| | | | |
|---|---|---|---|
| **Organization Sponsoring Clinic:** | | | |
| **Type of Clinic:** | | **Location:** | |

☐ **2. Sports Team Physician.**

| | |
|---|---|
| **Name of Team:** | |

☐ **3. Specialty Clinic under contract to a state agency.**

| | | | |
|---|---|---|---|
| **State Agency Sponsoring Clinic:** | | | |
| **Type of Clinic:** | | **Location:** | |

☐ **4. Supervised Hospital Fellowship.**

***Complete form #08-4288d in the application packet and submit with application.***

☐ **5. Emergency Response as part of organized response to a disaster or an emergency.**

| | |
|---|---|
| **Nature of Emergency:** | |
| **Location:** | |

☐ **6. Accompanying Employer-Patient.**

| | |
|---|---|
| **Employer/Patient:** | |

| | | | |
|---|---|---|---|
| **Applicant Signature:** | | **Date:** | |

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# Verification of Licensure – Courtesy License

→ **Applicant**: Please complete the top section of this form and forward a copy of this form to your state of residence. Type or print legibly.

| | | | |
|---|---|---|---|
| **Full Legal Name:** (Last, First, Middle) | | **Birth Date:** (mm/dd/yyyy) | |
| **Maiden or Other Names Used:** | | **Social Security Number:** | |
| **Mailing Address** | | | |
| **Medical/Osteopathic School Attended:** | | **Year of Graduation:** | |
| **Applicant Signature:** | | **Date of Signature:** | |

→ **Licensing Agency**: Please provide the information requested below for the physician identified in this form and send document directly to the Alaska State Medical Board at the letterhead address.

| | | | |
|---|---|---|---|
| **State Board or Licensing Jurisdiction:** | | **License Number:** | |
| **Initial License Date:** | | **Expiration Date:** | |
| **Basis of Licensure:** (FLEX, USMLE, etc.) | | **Current License Status:** | |

| | | | |
|---|---|---|---|
| **1.** | Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction? | **Yes** ☐ | **No** ☐ |
| **2.** | Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction? | **Yes** ☐ | **No** ☐ |
| **3.** | Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state? | **Yes** ☐ | **No** ☐ |
| **4.** | Is any such investigation or action pending? | **Yes** ☐ | **No** ☐ |
| **5.** | Are you aware of any derogatory information regarding this applicant? | **Yes** ☐ | **No** ☐ |

| | | | | |
|---|---|---|---|---|
| Board Seal | **Signature:** | | **Date:** | |
| | **Printed Name:** | | **Title:** | |

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# Fellowship Scope of Practice

→ **Applicant**: Please complete this top part and then send it to the supervising physician where you intend to serve in a fellowship.

| | | | |
|---|---|---|---|
| **Fellowship Applicant Name:** | | **Telephone:** | |
| **Mailing Address:** | | | |

→ **Supervising Physician**: Please provide the information requested below and return document directly to the Alaska State Medical Board at the letterhead address.

| | | | |
|---|---|---|---|
| **Supervising Physician:** | | | |
| **Alaska License Number:** | | **Telephone:** | |
| **Fellowship Specialty:** | | | |
| **Dates of Fellowship:** | **From:**_____ **To:**_____ | | |
| **Affiliated Hospital or Facility Name:** | | | |
| **Location:** | | | |

**Provide a description for the nature of the fellowship and the scope of practice for the fellow physician:**

The supervising physician shall immediately notify the board, in writing, of the termination of or any change to the supervisory relationship with the courtesy license holder. The supervising physician's responsibility continues until such written notice of termination or change is received by the board.

| | | | | |
|---|---|---|---|---|
| Notary Stamp | **Supervising Physician Name:** | | **AK license Number:** | |
| | **Supervising Physician Signature:** | | **Date:** | |
| | **Notary Public for State of:** | | **Subscribed and Sworn to Before me on this Day:** | |
| | **Notary's Signature:** | | **My Commission Expires:** | |

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# Verification of DEA Registration Status

Complete this top part and then mail it to the Drug Enforcement Administration (DEA) at:

→ **Applicant**:

Drug Enforcement Administration
Attn: Diversion Unit
300 5th Avenue, Suite 1300
Seattle, WA 98104

| | | | |
|---|---|---|---|
| **Full Legal Name:** | | | |
| **Other Names Used:** | | | |
| **Birth Date:** | | **DEA Registration Number:** | |
| **Mailing Address:** | | | |
| **Address of DEA Registration:** | | | |
| **Applicant's Signature:** | | **Date of Signature:** | |

→ **DEA Use Only**:

Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the Alaska State Medical Board at the letterhead address.

| | | |
|---|---|---|
| Has this applicant ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied? | **Yes** ☐ | **No** ☐ |
| Is any such investigation pending? | **Yes** ☐ | **No** ☐ |
| **DEA Comments:** | | |

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# Physician Board Action Data Bank Inquiry

Please complete the information below. Type or print legibly. **MAIL THIS REQUEST FORM TO:**
Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855

→ **Applicant**:

| | | | |
|---|---|---|---|
| **Full Legal Name:** (Last, First, Middle) | | | |
| **Birth Date:** (mm/dd/yyyy) | | **Social Security Number:** | |
| **Mailing Address:** | | | |
| **Medical/Osteopathic School Name:** | | **Location:** | |
| **Year of Graduation:** | | **If International graduate, ECFMG No.:** | |

→ **Applicant: Do Not Write Below This Line - Do Not Detach**

**Instructions to the Data Bank Staff:** Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

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Phone: (907) 465-2550

# Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Program Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  1. _____ _____
  2. _____ _____

**TOTAL:** 0

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

**Signature of Credit Card Holder:** _____

08-4438 Rev 12/26/18 Credit Card Payment Form (all major cards accepted)

**CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!**

1. Account Number: _____
2. Expiration Date: _____
3. Billing ZIP Code: _____
4. Security Code: _____

All four fields **MUST** be completed!

This section will be destroyed after the payment is processed.